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THE BRITISH JOURNAL OF DERMATOLOGY

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CONTENTS.

PAGE.

A Case of Trichophytic Granulomata. J. H. SEQUEIRA, M.D., F.R.C.P., F.R.C.S. 207

On a Useful Formula for the Treatment of Wide-spread Tinea Tonsurans. A. WINKELRIED WILLIAMS, M.D., D.P.H. 216

Royal Society of Medicine.—Dermatological Section.—Announcement.—Persistent circinate papulo-necrotic eruption (? tuberculide).—? Tuberculide of the type called "sarcoid" of Darier-Roussy.—Lupus erythematosus.—Generalised ichthyosis.—Hydroa-vacciniforme vel æstivale.—Case for diagnosis.—Tuberculide.—Pseudo-pelade.—Eruption due to ferrous iodide.—Case for diagnosis.—Syringoma.—Maculo-anæsthetic leprosy.—Lupus vulgaris and scrofulodermia treated by the Pfannenstill method.—Erythema nodosum, associated with mammary tuberculosis.—Ichthyosis 217

Current Literature.—A case of Sporotrichial septicæmia.—On Dermatitis nodularis necrotica.—A case of mercurial poisoning.—On pemphigus.—Contribution to the question of tattooing and syphilis.—The mottled chin in syphilis.—Eosinophilia in scabies.—Erythema nodosum syphiliticum.—A fatal case of blastomycosis 234

Quarterly Survey of Dermatological Literature . . . 238

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JUNE, 1912.

A CASE OF TRICHOPHYTIC GRANULOMATA.

By J. H. SEQUEIRA, M.D., F.R.C.P., F.R.C.S.

Under the title "Extensive Ringworm with Ulceration of the Umbilicus" I gave an account of the early history of the present case (1). The patient has been under observation off and on since then, and his later history seems worthy of record. I append a brief abstract of the early notes.

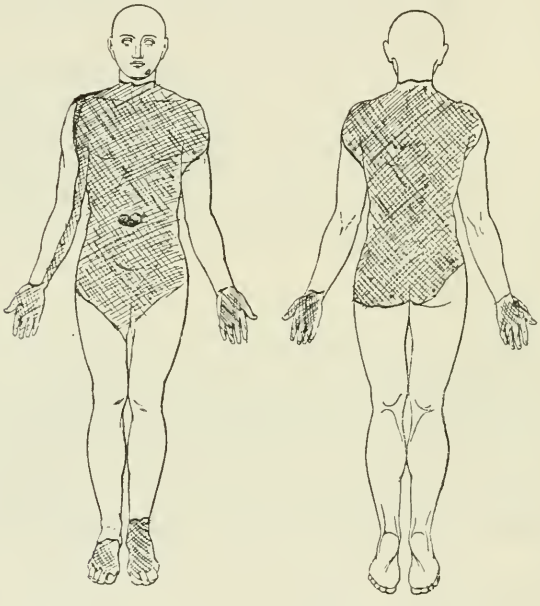
On October 5th, 1905, the patient, James C—, then aged 14 years, was sent to me at the London Hospital on account of a large ulcer of the umbilicus. On his being stripped it was at once seen that in addition to the ulcer there was a peculiar scaly condition of the skin of the trunk and extremities which further examination proved to be ringworm.

The boy was born and had always lived in the East End of London, in Limehouse. His father and mother were healthy. The father was a water-side labourer. He had never been out of England, and so far as I have been able to ascertain, there had been no contact with people who had been abroad. A sister, aged 21 years, suffered from the same disease. She had been affected for fifteen years, the boy for eight. No other members of the family had had any skin-affection.

The patient was well until 1897, when he was noticed to be suffering from "ringworms" of the body. So far as I could gather the disease was left untreated and gradually spread until the whole trunk and parts of the limbs were affected. An illness, said to be scarlet fever, followed, and from this he apparently made a rapid recovery. During the next year a swelling appeared about the

umbilicus, and this broke down and formed an ulcer, for which he was treated at a general hospital in 1903. The ulcer was then about the size of a half-crown piece. It was dressed with ointments and apparently healed up, but speedily broke down again and had given trouble ever since. In July, 1905, it began to enlarge, and in October he was brought to the London Hospital. Very little attention had been paid to the boy's health, and the conditions under which he had been living were very bad.

Fig. 1. Fig. 2.



James C— (front). James C— (back).
Extent of eruption in 1906.

On admission to the hospital the most striking feature of the case was a large reniform ulcer at the umbilicus. The ulcer was nearly three inches in its transverse diameter, and an inch and a half vertically. The margin was greatly thickened and indurated, and the edge undermined. In parts a probe could be passed under the edge for one third of an inch. The ulcer was half an inch deep in the middle. The base was irregular and covered with a yellowish-brown moist slough. There was a thin, yellowish purulent discharge. On the right wrist there was a circular infiltrated patch the size of a

penny. This resembled a local tubercular infection. It had never ulcerated.

The skin of the whole of the trunk was scaly. The scales were small, adherent, and of a brownish tint, and on close inspection raised red lines of papules in rings could be seen. These were most marked on the abdomen and lower part of the chest. The area involved in the scaly eruption is shown in the annexed diagrams (Figs. 1 and 2).

All the finger-nails were rough, thickened, opaque, and of a brownish tint in their distal parts. The thumb-nails were also involved, but to a less degree. The toe-nails were unaffected. With the exception of a small patch the size of a shilling on the left side of the chin the face was free.

The eruption itched a great deal, and the boy was constantly scratching.

The patient was well developed, but thin and anæmic. There was no evidence of visceral disease.

Scrapings taken from the skin and nails showed a large quantity of mycelium and some spores. The fungus did not differ microscopically from the common endothrix. Some of the exudate from the ulcer was examined by Mr. Twort in Dr. Bulloch's laboratory, and he obtained pure cultures of the fungus.

Dr. Colcott Fox was kind enough to make cultivations from some of the material, and he reported that the fungus was undoubtedly an endothrix. The colour was pale buff, and the crater was well marked (Fig. 10).

There seemed to be little doubt that the ulcer at the umbilicus was caused by the fungus. Microscopical sections of the edge showed a simple inflammatory infiltration.

The boy was in the hospital off and on for nearly two years. During that time a very large number of flat button-like lesions, varying from 2 millimetres to 2·5 centimetres in diameter, developed. Many of them were cured by the injection of carbolic acid. Some were scraped away, and strong antiseptics applied to the base. The lower portion of the left ear ulcerated and sloughed. The scalp remained quite free.

Iodine, chrysarobin, and many other antiseptics were used, and finally all the lesions cleared up, the umbilical ulcer healing after

prolonged immersion in a boric acid bath. The nails were removed by operation, and the beds dressed with a weak iodine solution.

The granulomatous eruption left extensive scars, the largest and thinnest being about the umbilicus. It is noteworthy that at no time was the hairy scalp affected except where the disease had extended from the left auricle.

The patient remained apparently well for a long time, though the nails never resumed their normal appearance. A second time the patient was admitted to the hospital (1908), and the nails were again removed and the bases dressed with iodine. He then passed out of sight and was at work. In November, 1911, he again attended the hospital, and was then suffering from a fresh outbreak of the granulomata. This had lasted for several months. There were large tracts of dry scaly eruption similar to those previously described, and in a good light it was easy to see that upon the dry scaly areas there were ringed, slightly raised papules covered with scales. In the right axilla there was an extensive granulomatous eruption of triangular shape and reddish-brown colour. It was covered with small rounded nodules except in the centre, where there was an ulcer of irregular outline, with undermined edges closely resembling the umbilical ulcer present in 1906. From the irregular base of the ulcer there exuded a thin sanious fluid. In the left groin there were numerous flat button-like nodules of a purplish-brown colour with smooth dry surface. These had identical characters with the lesions previously described. It was evident that the disease followed exactly the same course as on the former occasion. The fact that the nails have never been cured I took to be the cause of the recurrence. The patient was shown at the Royal Society of Medicine on November 16th, 1911, and he was then seen by Dr. Sabouraud, who very kindly offered to make cultures of some of the material and report upon them.

Nodules were removed from the axilla and submitted to Dr. Turnbull, who made the following report of the microscopical appearances.

The surface of the piece of skin is irregular, deep clefts passing into the centre. There is a thick layer of horn upon the surface. In places this is infiltrated by polymorphonuclear leucocytes. Many of the clefts are filled by desquamated horn- and pus-cells. Other clefts lose their epithelium and end in abscesses. The periphery of these abscesses is occupied by a granulation-tissue consisting chiefly of large

Fig. 3.—Granulomata in right axilla. Scars of old lesions.

Fig. 4.—Granulomata in left groin. Scaly eruption in both groins and scars of old lesions.

To illustrate Dr. J. H. Sequeira's Article on a Case of Trichophytic Granulomata.

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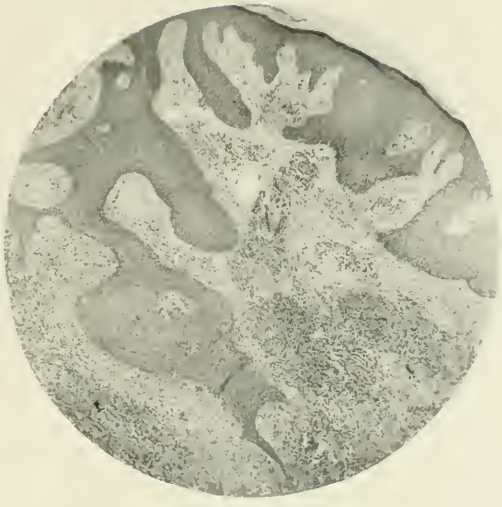

Fig. 5.—Section of granuloma under low power.

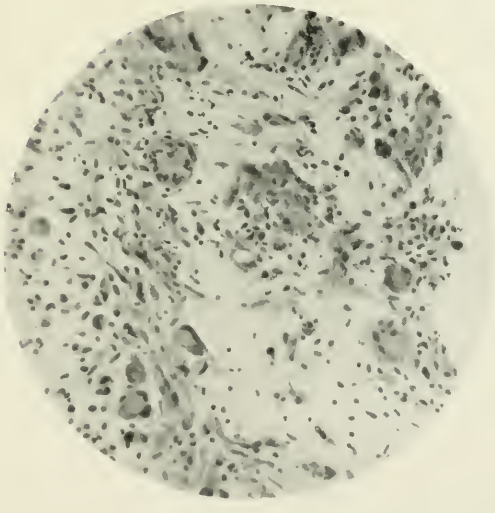

Fig. 6.—Section of granuloma under high power showing giant-cells.

To illustrate Dr. J. H. Sequeira's Article on a Case of Trichophytic Granulomata.

giant-cells with ill-defined borders and peripheral nuclei. Their protoplasm is stained faintly and is usually finely, sometimes coarsely, vacuolated. These giant-cells are also found immediately below the basal layer of the epidermis in places where there is no destruction of the epidermis by abscess formation. The rest of the dermis is infiltrated by very large numbers of lymphocytes and plasma-cells together with some eosinophile leucocytes. Where pus is present Gram-positive cocci are found. In the giant-cells there are trichophytic filaments.

Their position is best seen in Twort's stain. They are straight or slightly sinuous rods containing spores, which are usually smaller at one end of the rod than the other or smaller at both extremities. One apparently branched example was found. The spores are barrel-shaped as a rule, typical examples measuring 7·5 μ by 3·8 μ. The spores are usually set close together, the adjacent ends being somewhat flattened. In Twort's stain the wall of the refractile spores is stained red, whilst the homogeneous rod in which they lie is apparently green. Where, however, the spores are separated a narrower red rod joins them. In Weigert-Gram the rows of largest spores are

embedded in a deeply stained blue rod. In this stain much narrower, sinuous, unbranched rods are present which are stained in a speckled manner throughout. There are also rods of slightly greater breadth in which occasional small spores are present. The rows of spores can be recognised within giant-cells in sections stained by hæmatoxylin and eosin or van Gieson. In the former stain the wall of the spore is stained by hæmatoxylin. There are also in the section small groups of spherical bodies which are about the size of a red corpuscle, some

Fig 10.

Photograph of Dr. Colcott Fox's culture made in 1906.

being larger, others smaller. They are stained in hæmatoxylin and eosin and Weigert Gram very like the red corpuscles, but in Gram they retain the stain; in Twort they are pink, whilst the red corpuscles are green. The majority lie in the infiltrated portion of the dermis; some lie amongst the giant-cells. They are not found in contact with the spore-bearing rods. No rods are present in the epidermis.

The fungus as grown from scrapings of the epidermis and found in the granuloma was identified by Dr. Sabouraud as the Trichophyton plicatile.

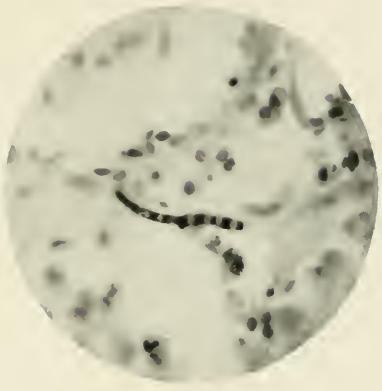

FIG. 7.—Micro-photograph showing mycelium of Trichophyton plicatile in tissue. Stained Weigert-Gram. $\frac{1}{12}$.

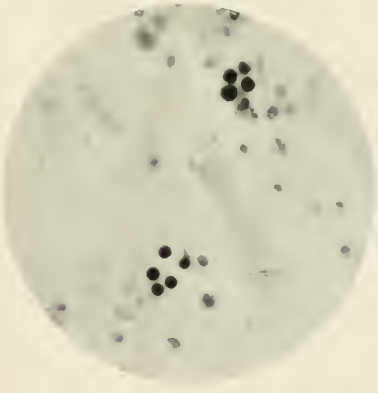

FIG. 8.—Micro-photograph of conidia-like bodies in section. Stained Weigert-Gram. $\frac{1}{12}$.

FIG. 9. Photograph of Dr. Sabourand's culture of Trichophyton plicatile from scrapings taken from Dr. Sequeira's case. October, 1911.

TO ILLUSTRATE DR. J. H. SEQUEIRA'S ARTICLE ON A CASE OF TRICHOPHYTIC GRANULOMATA.

The Trichophyton neo-endothrix, variety plicatile, was described by Sabouraud in 1909. In his work, *Les Teignes* (2), he states that he had only seen it twice in five hundred cases, both in cases of beard ringworm. The first case was a suppurating ringworm of the beard, the lesion resembling kerion, rounded, indurated, with its surface covered with pustules. The hair was broken short. In the second case the lesions were primarily dry, with red circles covered with broken hairs, but later there developed numerous intra-dermic nodules, discrete and coalescing, and attended with pain.

On microscopical examination the mycelium was found both inside and around the hairs in the form of ribbon-like filaments.

The cultures are remarkably like those of the crateriform type of trichophyton. They are white and of cardboard-like consistence with a powdery surface. "The surface," Sabouraud remarks, "gives the impression of a silky material which has been allowed to form folds" (*vide* Fig. 9).

The Trichophyton plicatile can be inoculated into the guinea-pig.

Although Dr. Sabouraud had only met with two cases in which he had found the Trichophyton plicatile, it is of great interest to know that the fungus is far from uncommon in Copenhagen, for in a recent communication made at the First Northern Dermatological Congress at Copenhagen, Dr. Bang (4) reported that this fungus was the commonest met with in Denmark. He describes four types of lesion produced by the organism:

(1) A dry type with a more or less ringed-form eruption. The affection is pilar.

(2) An impetiginous form often complicated with the following.

(3) A sycosiform variety with a firm infiltration in the skin and deep small suppurative lesions.

(4) A kerion form in which there are round or oval plaques characterised by follicular inflammation.

Dr. Bang reports fifty cases of Trichophyton plicatile, of which thirty-nine were in the beard. One case of the dry scaly eruption had lasted for six months; others were of four months' duration.

Trichophytic granulomata appear to develop in two forms. Sometimes there is a common, chronic ringworm, or a more acute lesion upon which a nodular growth develops. In the second type there is a plaque which is studded with nodules. This condition may occur

on the scalp or the beard region, or on the glabrous skin. This form is represented in the case under discussion.

Majocchi (3), in 1883, first described the condition known as Granuloma trichophyticum, and most of the cases observed have occurred in Italian clinics. In Majocchi's original case there were neoplastic nodules characterised by epithelioid and giant-cells, and definite trichophytic elements were present in the nodules. Campana described a similar condition in the perinæal and scrotal regions (5). Pini (6), working in Majocchi's clinic, contributed a careful account of a case in 1897. The neoplastic nodules were of almost fibrous consistence, discharging pus, blood, and a yellowish-red fluid. The elastic tissue of the derma was destroyed in the central parts of the growth, and the abscess cavities were surrounded by epithelioid cells and giant-cells. Colombini and Mazza also record cases. Mazza (7) looks upon the trichophytic granuloma as distinct from kerion and from sycosis. He believes the suppuration to be an epiphenomenon. In an important paper Vignolo-Lutati (8) demonstrated that the granulomata develop in the derma and that the follicles are affected. The parasite makes its way into the true skin, and there excites a reaction similar to that produced by the *Bacillus tuberculosis*. Reproductions of plates from Vignolo-Lutati's paper are given in Sabouraud's *Les Teignes*, p. 480, *seq*. Sabouraud himself records a case in which an area upon the back of the hand suggested lepra. The patient came from the Antilles. The supposed leproma was found on microscopical examination to contain a fragment of hair in the centre of each nodule. The hair was infected with the ringworm fungus, and surrounding it was a granulomatous formation. He was led to believe that in all these cases an infected hair was the starting-point of the granulomatous infiltration (9). This does not appear to have been the case in the patient here described. There was no trace of any hair involvement in the sections made, but of course in so long-standing a condition it would be impossible to be dogmatic upon the point.

It is rather curious, considering what is now known of the granulomata caused by sporotrichia and other allied fungi, that granulomatous reactions are not more common from trichophytic infection. It may be that the trichophyta find it difficult to develop deeply in the tissues. The variety of trichophyton does not appear

to be of supreme importance, for Mazza found the Trichophyton violaceum in one case, Sabouraud in one case, while Pini found a trichophyton with a yellow powdery culture in one instance. This last Sabouraud believes to be the Tr. cerebriforme or the Tr. regulare. Another of Pini's cases gave a snow-white culture, probably the Tr. gypseum.

The case I have ventured to describe at so great length is the only one of its type recognised in this country, and possesses features differing from the Continental cases. As regards the source of infection, my impression is that the patient contracted the disease from his sister, who was infected on the hand and arms when I saw her in 1905. She was at the time of her infection engaged in rag-picking, a very dirty occupation, which might bring her into contact with infected clothes from other countries, as the family lived in a poor locality by the riverside in East London. The infection may possibly have come from Denmark.

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(1) Sequeira.—*Brit. Journ. Derm.*, August, 1908.

(2) Sabouraud.—*Les Teignes*, p. 332.

(3) Bang.—*Trans. Nord. Derm. g. Knogress*, p. 14, *seq.*

(4) Majocchi.—"Sul granuloma tricofitico," *Atti dell VII riunione della Societa Ital. di Derma e Sifil.*, Milan, September, 1906.

(5) Campana.—"Trichophytiase dermique," *Giorn. Ital. d. Mal. Ven. e della Pelle*, July–August, 1887.

(6) Pini.—"Granuloma trichophyticum Majocchi," *Derm. Zeitschrift*, 1902, p. 710, fasc. vi.

(7) Mazza.—"Ueber das Granuloma trichophyticum Majocchi," *Archiv f. Dermat. u. Syphilis*, 1907, vol. xxxvii, p. 25.

(8) Vignolo-Lutati.—*Monats. f. prakt. Derm.*, vol. xlvi, 1908.

(9) Sabouraud.—*Les Teignes*, p. 480, *seq.*

CLINICAL NOTE.

ON A USEFUL FORMULA FOR THE TREATMENT OF WIDE-SPREAD TINEA TONSURANS.

By A. WINKELRIED WILLIAMS, M.B., D.P.H.

Formula: R Camphor
Spt. vini rect. (vel Meth.), āā ℥iv
Acid picric, gr. vij
Sig. inflammable. To paint all over scalp twice daily.

The above formula was given by a patient to my colleague, Dr. Hobhouse, a few months ago, and he gave it me to try.

I have now treated a number of cases with it, and find it to be remarkably efficacious.

The first case was an old-standing universal microsporon of scalp which had been under various treatments for over three years and was still very bad. After three weeks' application of this formula I failed to find any ringworm stumps, but continued the application once daily for another fortnight. The patient has now ceased treatment, beyond 10 gr. in ℥j white precipitate ointment (as a precaution at school). The hair is growing well and thickly, and no ringworm stumps can be found. There has not been any tenderness or discomfort in the scalp during the treatment. All the other cases are doing equally well, excepting in one or two a little tenderness and slight smarting is felt, but most of them have experienced no discomfort whatever. Generally the ringworm hairs are loosened and come away with the bulb in from ten to thirty days.

I now direct the hair to be clipped absolutely close and the application to be freely painted on twice daily, and the scalp washed once or twice a week, and a calico cap to be worn during the treatment.

So far I have not investigated the histology of the stages of loosening of the hairs, nor the rate of loss of vitality of the fungus by culture methods, and the possible infective character of the yellow powder the application leaves on the scalp.

The only objection to the treatment, as far as I can tell, is the

yellow staining of hair, which is still noticeable three weeks after stopping the treatment.

Camphor and spirit do not appear to be efficient without the picric acid; spirit and picric acid alone I am now trying.

I think the good results of the remedy justify the publication of this preliminary note without waiting for a more definite investigation of its *modus operandi*.

ROYAL SOCIETY OF MEDICINE.

DERMATOLOGICAL SECTION.

Meeting held on Thursday, May 16th, 1912, Sir Malcolm Morris, K.C.V.O., President of the Section, in the Chair.

Announcement.

The President announced that the next meeting of the Section would be held in the Society's new house at five; and it would be followed by an evening meeting for the discussion of the subject of "Prurigo." Members would have the opportunity of reading the paper in advance, therefore it would not be read at the meeting, and the whole time would be devoted to debate.

Dr. H. G. Adamson showed (1) a case of *persistent circinate papulo-necrotic eruption* (*? tuberculide*). The patient, E. L—, aged 1 year and 7 months, was in St. Bartholomew's Hospital under the care of Dr. Herringham, who had kindly allowed him to exhibit the case. The eruption occupied the forearms, hands and fingers, and the legs below the knees and the feet and toes, with a lesion also upon the right cheek and another upon the margin of the right ear. It consisted of papules, which, while expanding into rings, necrosed, and left behind them punched-out scars. The mother said that the eruption had been present on and off since birth, when it had been noticed as "spots" on the fingers and toes. The child was well nourished, but there were evidences of "chilblain circulation" in the cold and dusky hands and feet, and in a marked livedo annularis on the limbs. The case had been under observation for five months, and during that time there had been successive crops of the eruption.

At present there was upon both forearms and hands and on both legs and feet an eruption in various stages of development: (1) A few hemp-seed-sized reddish-brown firm papules; (2) many split-pea-sized papules, with black crusts over their central part; (3) rings of the size of a threepenny-piece up to that of a florin, made up of a narrow red-brown slightly raised infiltrated margin, enclosing an area of scar-tissue; and (4) many purplish punched-out vacciniform scars, marking the sites of former lesions. By watching a papule during its evolution it was found that it passed through these various stages in about two weeks. On the right cheek there was a patch of the size of a shilling, which had a raised nodular margin and a slightly atrophic centre. There were two small crusted nodules on the margin of the right ear.

In addition to the eruption described, there had appeared on the hands and feet from time to time dusky purplish puffy swellings somewhat resembling chilblains. Sometimes one or more fingers or toes were entirely involved by the dusky, puffy swelling. While these swellings were present the general duskiness of the extremities was more marked.

A von Pirquet test was negative, but after injection of ·0002 c.c., ·0005 c.c. and, finally, ·001 cc. of old tuberculin there had been a general reaction with rise of temperature to 101·2° F. The Wassermann reaction was negative.

There were four other children in the family, three of whom were well, but the fourth (a boy, aged 4½ years) had had the same sort of eruption and dusky hands and feet since a few months of age. The eruption had been seen by the exhibitor, and it was identical with that of the child now shown.

The clinical features of the case suggested a tuberculide of the papulo-necrotic nodular type, but there were two unusual circumstances: The eruption had been present since birth, and the lesions had a marked tendency to spread into rings.

Microscopical examination had not helped the diagnosis. Although there were cell infiltrations mainly around the sweat-ducts and glands —as is often the case in tuberculides—there were no giant-cells nor "epithelioid" cells, the cell infiltration being made up of fibroblasts (mononuclear round-cells) suggestive perhaps of a toxic action, but not characteristic of a tuberculide.

(2) A case for diagnosis of *? tuberculide of the type called "sarcoid" of Darier-Roussy*. The patient was a woman, A. A—, aged 35 years. Six weeks ago she had noticed a spot of the size of a pin's head behind the ankle on the outer side of the left foot. This had increased in size and others had formed, and there was now a group of eight or nine pea-sized nodules occupying an area of about 1½ in. by 2 in. The nodules, though deep-seated, seemed to be in the skin and not subcutaneous. Some were dusky red, but the skin was nowhere broken. The whole area in which they were set was slightly red and infiltrated. There was no tenderness. On the dorsum of the right foot were two nodules, very hard, deep seated, and giving the impression of "rheumatic nodules." The patient had a phlyctenular conjunctivitis of three weeks' duration. There was a long scar in the neck where glands had been removed at sixteen years of age. A nodule was excised for microscopical examination, but the sections had shown little if any change beyond a very slight cell exudation around the blood-vessels of the corium. Clinically the case seemed to be a "tuberculide" of the type of Darier's "sarcoid hypodermique," but the microscopical examination appeared to negative this.

Dr. J. L. Bunch showed a case of *Lupus erythematosus*. The patient was a nurse, aged 23 years, who had been sent to him by Dr. Bowes, of the Surrey County Asylum. Some nine months ago a few small, slightly scaly patches had made their appearance on the backs of the hands, which latter were inclined to a purplish tinge and had a somewhat chilblain appearance. These scaly lesions were originally never larger than a pea, but, as they increased in number, some of them tended to coalesce and thus formed patches sometimes as large as a hazel-nut. The edges of these lesions were fairly sharply defined and slightly thickened, but their chief characteristic was that they went on to atrophy. At the present moment there were numerous small atrophic scars on the dorsa of the hands and fingers, marking the site of old Lupus erythematosus lesions, in addition to more recent active foci of disease.

A few of these recent spots had shown a yellowish centre, and the question arose whether these pointed to a secondary staphylococcic infection or to a co-existing folliclis.

Some weeks ago an erythematous, slightly scaly patch had made its

appearance on the left cheek, and when shown this was about three quarters of an inch in its longest diameter, with a somewhat purplish tint in the centre and a pink or reddish edge. This patch showed up to the present no signs of atrophic change.

A week previously a von Pirquet reaction had been done, but this had proved negative. No Calmette reaction had been tried and no injection of tuberculin given.

The PRESIDENT said he did not doubt that it was an erythematous lupus process in each area. About a year ago he showed the case of a doctor's dispenser with exactly the same condition on the hands; she had since enormously improved, but was not yet well. Many of the patches on the hands had atrophied, as had happened in this case. They were equally localised. To improve the circulation he used a constant current, which often made considerable difference. Such conditions as this, practically on the border-line between two diseases, were always interesting.

Dr. J. L. BUNCH showed a case of *generalised ichthyosis* in a girl, aged 14 years. Soon after birth it was noticed that the skin was harsh and dry, and this condition of the epidermis gradually became more marked until the whole of the trunk, limbs and face became rough, scaly, and markedly wanting in elasticity. When first seen, a month previously, the face and scalp were scaly and dry, the hair was wanting in lustre and harsh to the touch, the trunk and extensor surfaces of the limbs were covered with coarse, irregularly shaped scales, especially well marked on the backs of the wrists, the knees, and the fronts of the ankles. The scales were of a dirty greyish colour and had an unwashed appearance; the natural lines of the skin were exaggerated and the affected areas felt dry and harsh. The plate-like character of the scales was suggestive in places of the so-called "alligator skin."

The anterior margins of the axillæ and the outer surfaces of both thighs were marked by the presence of warty, thickened, papillary elevations of a dark grey tint, some of which had a spine-like appearance, which strongly suggested a diagnosis of Ichthyosis hystrix, and the case was shown as possibly one of the "mixed variety," combining some of the characteristics both of Ichthyosis simplex and Ichthyosis hystrix.

The history seemed to show that the lesions tended to improve in warmer weather, and in summer the papillary elevations were stated to diminish, if not disappear.

The PRESIDENT said that much good was derivable also from prolonged sulphur baths.

Dr. MACLEOD said he had employed thyroid extract with distinct benefit in several cases of generalised ichthyosis at the Victoria Hospital for Children, especially when it was pushed to the point of toleration. The local application which he had found of most use was a drachm of resorcin and an ounce of glycerine and starch.

Dr. DORE showed (1) a boy, aged 8 years, suffering from *Hydroa-vacciniforme vel æstirale*. The boy presented a vesico-bullous scar-

Dr. Dore's case of Hydroa.

leaving eruption on the face, especially on the nose, cheeks and forehead, on the rims of the ears and dorsal surfaces of the hands. The eruption had occurred every year for the past four years, and persisted from the month of March to September each year. It came out in crops, each crop lasting about a month or five weeks, and directly followed exposure to sun or wind. He had never had an attack in the winter. The lesions began as small vesicles, which enlarged and dried up in the centre, leaving a ring-shaped vesicle at the margin resembling that of vaccinia. Some of the vesicles showed umbilication, some of them were loculated, while others had become

pustular or dried up to form brown crusts. Cultures from the vesicles gave a pure growth of *Staphylococcus aureus*.

The boy appeared in other respects to be in excellent health, and was the only member of the family affected in this way. There was no reducing substance or visible pigment in the urine, but the spectroscopic test for hæmatoporphyrin had not been employed.

The PRESIDENT said it was puzzling to account for the involvement of the mucous membrane of the mouth on the idea that it was due to exposure to the cold winds in the spring.

(2) A *case for diagnosis* in a woman, aged 54 years. She presented two symmetrical raised brownish-red, gelatinous-looking oval swellings about half an inch in length over the nasal bones on each side, which had persisted without change for eight months. In addition to these there were small symmetrical patches consisting of an aggregation of yellowish papules like those of Lupus vulgaris, but disappearing on pressure on the ears just above the tragus and a few inside the concha. Scattered over the upper part of the front of the chest were a large number of flat, shiny yellowish papules or irregular-shaped patches. There was no infiltration or redness, and these lesions had

remained stationary for five months. The patient gave a history of an attack of "itching eczema" all over the body four years previously. She had had five healthy children, one miscarriage between the first and second, and her third child died at the age of five months, but there was no other evidence suggesting a diagnosis of syphilis, and the Wassermann reaction was negative.

The opinion of several of the members present was that the case was an unusual one of Lupus erythematosus.

Dr. Dore's case of Hydroa.

(3) A *tuberculide* in a boy, aged 10 years. The lesions began five months ago on the buttocks, where there was a characteristic eruption of Acne scrofulosorum. On the legs there were large circular, scaly, infiltrated patches of various sizes. The boy appeared to be in good health and had no enlarged glands or other evidence of tuberculosis. An uncle was said to have tuberculous glands, but he was the only relative known to be affected. The boy was brought forward as a good example of a mixed tuberculide and also for suggestions as to treatment.

Dr. Wilfrid Fox showed a case of *pseudo-pelade*. The patient was

a young woman, aged 21 years, who had suffered from the condition for the last four years. She showed one of those scarring alopecias, which was certainly neither Lupus erythematosus nor Acne decalvans, and appeared to be of the type referred to by Brocq under the name of "pseudo-pelade." The areas of alopecia were irregular in shape, mostly about the size of a postage stamp, and situated chiefly in the mid-frontal region, though some of the more recent ones were spreading on to the parietals. They were dead white in colour, shiny, slightly depressed, and with complete atrophy of all the hair follicles; in some places they ran into one another, in others a few straggly hairs separated the areas. During the last four months there had been no fresh foci appearing, but the patient said the areas were in the first place tender and slightly pink in colour, the pink coloration being diffuse over the whole area and not due to individual folliculitis. There were no injected venules present in any of them.

The exhibitor mentioned that he had recently had another case of this same disease in a man who had spent most of his life in exploring in Africa, and this patient put it down to the effects of sunburn.

Dr. E. W. Goodall (introduced) showed a case of *eruption due to ferrous iodide*. John W—, aged 23 years, was admitted to the Poplar and Stepney Sick Asylum on February 7th, 1912, for mitral regurgitation and nephritis. There were œdema of the lower extremities and signs of heart failure. The nephritis continued up to March 26th. On April 3rd the patient suffered from vomiting and headache. On the 13th a diastolic murmur appeared, and as previously only a systolic had been present it was thought that malignant endocarditis was setting in.

On the evening of April 12th papules began to come out on the face. Within twenty-four hours they were vesicular. The eruption

continued to come out during the next four days. I saw the patient on the 16th. The face and neck to the extent shown in the photograph were covered with a vesiculo-pustular eruption, confluent about the nose, lips and adjacent parts of the cheeks, discrete elsewhere. The colour of the vesicles was a pale yellow, like that of smallpox in the late vesicular stage. On pricking the vesicles a whitish, thick fluid escaped. The discrete vesicles were monolocular and there was no umbilication. Some of the lesions about the nose and lips were beginning to scab. The eruption was painful, especially when touched. There was a good deal of swelling of the eyelids, nose and lips. There were no lesions on the tongue, palate or buccal mucous membrane. The lesions were very superficial, so that on rolling them

between the finger and thumb there seemed to be little or no infiltration of the skin.

On the shoulders and upper part of the back were a number of papules. Most of them were ordinary acne pimples with a central black spot, but there were a few vesicles. There were a few vesiculopapules on the chest and one or two about each wrist, but only one of the latter was of any size. It was situated on the inner side of the forearm just above the wrist, and had much the appearance of a smallpox papule just becoming vesicular. There were also several similar lesions on the scrotum, penis, and adjacent portions of the thighs. There were none anywhere else on the lower extremities.

The aspect of the eruption had raised a suspicion of smallpox, and I was not surprised to hear this when I saw the patient on April 16th. The photograph was taken the next day, and by that time a good deal more scabbing had taken place. The eruption gave off an offensive odour. There were four good vaccination marks on the left upper arm, the result of vaccination in 1902.

There had been a little irregular pyrexia from April 1st to 7th, and the temperature again rose while the eruption was coming out, and reached its highest point, 103° F., on the evening of April 13th. Then it gradually fell till the death of the patient, which took place on the 18th, from cardiac failure. He had for two or three days previously been dull and apathetic.

The only cause I could find to account for the rash was ferrous iodide; the patient had taken three doses of the syrup of the iodide of iron on each of the two days April 11th and 12th—six doses in all. He therefore took altogether 32·7 gr. of ferrous iodide. He had never, so far as is known, taken iodides before.

I have thought that this case was worthy of record because it gave rise to the suspicion that it was one of smallpox. Rather more than six years ago I saw a similar case, in which the diagnosis of smallpox was actually made and the patient sent to the smallpox hospital. She was a woman, aged 32 years, who was the subject of chronic heart disease and right hemiplegia. The eruption came out suddenly after she had taken about 60 gr. of iodide of potassium in 10-gr. doses. Up to eight days previously she had for several days been taking 3-gr. doses of the same drug, but had not shown any signs of iodism.

For the opportunity of seeing and the permission to record the present case I am indebted to Dr. Charles Spurrell, the Medical Superintendent of the Sick Asylum.

The PRESIDENT showed a *case for diagnosis* (ferrous iodide rash). The patient had an eruption on the face and legs, and the duration had been three months. There was nothing abnormal to be seen in any other part of the body.

The PRESIDENT said he was not very familiar with these cases of eruption due to iodide of iron. His own case looked so very much like one of specific eruption that at first he was inclined to be deceived. He was given one teaspoonful of syrup of iodide of iron three times a day, and in a week the eruption appeared. The medicine was stopped and then the eruption came out again. Though iodide of iron must be given very commonly, such an eruption was, in his experience, rare. The Section was much indebted to Dr. Goodall for bringing such a case, as these cases were instructive, and if he had any others of interest he hoped he would bring them.

Mr. J. E. R. McDONAGH showed a case of *syringoma*. A girl, aged

Section of Mr. McDonagh's case of Syrin goma.

12 years, came up to hospital complaining of some spots on her chest. According to the mother's history the spots appeared when the child was one year old, no other member of the family being affected.

The lesions were very faint yellowish-white, raised above the surface of the skin, and varied in size from that of a pin's head to a lentil. The lesions were smooth on the surface, skin not movable over them. They were sharply circumscribed, although the bigger ones were not invariably regular in outline. The lesions gave rise to no subjective symptoms.

The area most affected was the chest over the sternum and beneath the clavicles, and in these situations the biggest lesions were to be found. The neck was also involved, lower eyelid on left side, lateral walls of thorax and abdomen and inner sides of thighs. There were none on the back or arms.

Histology.—The epidermis over the new growth, which was situated in the upper portion of the corium, was unaltered. The corium itself was unchanged except for the presence of the epithelial elements from which the new growth arose, and also for a slight increase in the fixed connective-tissue cells. The new growth consisted of the following structures:

(1) Solid cords and nests of epithelial cells.

(2) Cords and nests of epithelial cells which were hollowed out in the centre, the walls of the former being made up of two layers of epithelial cells, the latter of several layers with the central cells degenerated and staining badly. The hollow cords resembled in every way the normal sweat-ducts.

(3) Small cystic spaces with a colloid content. The walls were made up of one or two layers of epithelial cells; in parts the cells were indistinct and the nuclei when present were elongated. The colloid matter was most marked in those cysts the cells in the walls of which had degenerated, and the homogeneous substance in the centre was probably a degeneration product of those cells.

Dr. MacLeod showed a case of *maculo-anæsthetic leprosy* in a woman, aged 25 years—a Creole from West Indies. Her father was an Irishman, and her mother a native of the West Indies. She was the youngest of three children, having a brother and sister who were both married and had healthy children. Her father died when she was young, the cause of his death being unknown to her. Her mother also suffers from maculo-anæsthetic leprosy.

The patient is a well-nourished young woman of medium height

and rather stout. The disease was first noticed when she was nineteen years of age as a reddish patch about the size of a shilling not unlike ringworm on the back of the right wrist. This gradually spread, taking a year to reach the size of half-a-crown, when it began to assume the characteristics of a maculo-anæsthetic patch of leprosy. She was then put under treatment for the disease. In 1909 she came to England, and since then has been under the observation and treatment of the exhibitor. When she was first seen in 1909 in London the following evidences of the disease were present. Extending across the back of the right wrist there was a band of discoloured skin, which varied in width from one to two inches. It was reddish-purple in tinge in the centre and brownish at the margins, the border being slightly raised. The affected skin was slightly atrophic, but the lanugo lavis were still present upon it. A smaller patch about the size of a shilling was present on the back of the hand; this was similar in colour and texture to the larger patch. These lesions were definitely anæsthetic, insensitive to pain from the prick of a needle, insensitive to heat and cold but slightly sensitive to touch. The skin beyond the patches was slightly hyperæsthetic. There was also a small patch on the front of the chest. In addition to the patches on the skin there was slight wasting of the interosseous muscle between the fourth and fifth metacarpal bones. There was no definite thickening of the ulnar nerve. The patient complained, however, of tingling and peculiar shooting pains along the nerve just as if it had been knocked at the elbow. These sensations were specially marked when she tried to lift anything. These were the only signs of the disease, and otherwise the patient seemed to be enjoying excellent health.

It was decided to treat the case by nastin injections. The injections of 1 c.c. of nastin B1 were begun in March, 1909, and were given subcutaneously into the thighs. There was no definite pain associated with the injection, and there was neither a local nor a general reaction. The treatment was continued for five months, but in spite of it the patches appeared to be increasing in size, and the patient complained of numbness of the little finger, which was a new symptom. Consequently injections of nastin B2 were substituted, but with no more definitely beneficial results. The nastin treatment was continued until July, 1911, and as there had been no marked

change for the better it was decided to replace it by injections of a leprolin, prepared by Dr. Bayon from a streptothrix which he had isolated from another case, and which he believed to be the specific micro-organism of the disease. These injections have been continued intermittently since then. Only in one or two instances has there been any reaction from them, and then it was simply in the nature of a slight febrile disturbance, which took place about eight hours after they were given. Recently the disease has remained stationary, and the patches have faded to such an extent that it is difficult to detect them on casual observation.

The case was shown on account of the difficulties which may be met with in the diagnosis of early maculo-anæsthetic lesions, and also from the interest connected with the fact that the patient, while under nastin treatment, remained *in statu quo*, but since Bayon's leprolin has been injected has shown decided improvement. In a disease, however, which is prone to exacerbations and remissions apart from treatment, it is impossible to come to any conclusion from an isolated case with regard to the merits of any individual form of treatment.

The PRESIDENT said that in one case there was a very great increase of pain from the administration of the nastine. He did not know whether members had tried tuberculin in an anæsthetic case of leprosy. When tuberculin first came in he had a case of anæsthetic lepra in his ward and gave him some tuberculin, and after the first injection there was a violent reaction, with large bullæ all over the arms, a very severe attack, such as he had never had before. It had been anæsthesia with macular patches, and nothing else. No further dose was given, and the condition quieted down. Since that time the patient had been living quietly in the country, and the disease had not progressed.

Dr. COLCOTT FOX said he could confirm what the President said by an experience made when Koch's first tuberculin was introduced. By the kindness of the Medical Superintendent of the Greenwich Infirmary, he presented at one of Sir Watson Cheyne's demonstrations an old woman who had suffered from anæsthetic leprosy for many years and in whom the disease appeared quiescent, and only some dystrophies of the extremities were noticeable. She reacted to tuberculin, and a large circinate erythematous eruption evolved which was apparently of a leprous nature.

Dr. SEQUEIRA showed a case of *Lupus vulgaris and scrofulodermia treated by the Pfannenstill method.* The patient was a poorly developed girl, aged 16 years. Her father was healthy, but her mother suffered from phthisis. The girl had always been delicate.

She had pneumonia when young, and had had measles fifteen months ago. The lupus started upon the back of each wrist eight years ago, and the lesions had been scraped at another hospital. They gradually spread after the operation, and eventually reached the elbow and the upper arm. A little later the face was affected. Fifteen months ago she had what was described as being a tubercular abscess behind the left ear. This was opened. Her hearing became affected, and she was very deaf. Her voice also was husky.

She came to the London Hospital in January, 1912, with extensive lupus of the nasal cavity and of the pharynx and palate. There was also double epiphora. There was extensive lupus, with scarring upon the hands and forearms up to the elbow. In February, 1912, the back of the right hand became much swollen and œdematous and a localised purplish-red swelling developed over the back of the right wrist. This was about two inches in its long diameter and one and a half inches transversely. The swelling evidently fluctuated, and it was opened, and a thin yellowish pus was evacuated. Later, a small oval swelling formed along the line of the lymphatics.

On February 21st she was admitted to the ward, and the arm was put on a splint.

The ulcerated areas in the nose were treated by packing with gauze, which was kept constantly moistened with a solution of peroxide of hydrogen 10 vols. At the same time she was given 30 grains of sodium iodide *per diem* in divided doses. The tampons soaked with the peroxide were kept constantly in position, except when the patient was asleep. Finding so much improvement of the intra-nasal condition in this as in numerous other cases by the Pfannenstill method, the exhibitor had the ulcerated areas upon the forearm and wrist dressed in similar fashion with great benefit. The case was specially shown to illustrate the value of the method, particularly in the treatment of ulcerative lupus of the cavities. The patient has borne the iodide very well, and to make sure that the condition was not complicated by congenital syphilis a Wassermann reaction was done, with negative result. The patient has put on seven pounds while in hospital, and her general health has improved greatly.

Dr. PERNET said that last year in Stockholm in the late Professor Möller's clinic he had seen the Pfannenstill method employed in Lupus vulgaris of nasal cavities. The treatment was giving satisfactory results.

Dr. F. Parkes Weber showed a case of *Erythema nodosum, associated with mammary tuberculosis.* The patient was a rather delicately built woman, aged 47 years, who had previously had no serious illnesses and had apparently enjoyed good health. She was admitted into the German Hospital on April 6th, 1912, suffering from a chronic swelling in the right breast of at least two months' duration, which had not caused her much pain. This was excised by Dr. E. Michels on April 9th and was found to be tuberculous, the microscopical sections containing many characteristic giant-cells of the tuberculous type. On admission she was likewise suffering from florid erythema nodosum affecting both legs up to just above the knees, and there was a little pyrexia. The Erythema nodosum, which had commenced about March 30th, almost completely disappeared by the end of April. The patient had not been taking any drug, such as potassium iodide, which might be supposed to be connected with the onset of the Erythema nodosum. There was no history of syphilis. She had had twelve children, nine of which were still living; no miscarriages. A good deal of attention had been given, especially on the Continent, to the occasional association of Erythema nodosum with tuberculosis,* a connection which had been recognised and described by Landouzy in 1907.†

Dr. Whitfield remarked that Erythema nodosum in association with tubercle was said to be of very fatal omen. In some cases it was associated with severe tuberculous adenitis and pulmonary tuberculosis, but he had seen such cases recover and he doubted the gravity of the significance.

Dr. Sequeira remarked that Erythema nodosum had been known to follow injections of tuberculin, and recalled two cases in which lesions of this type had followed injections of the bacillary emulsion for articular and gland tuberculosis.

Dr. Winkelried Williams showed a case of *ichthyosis.* This case showed certain unusual features, which made the diagnosis uncertain.

* See A. B. Marfan, *Presse Médicale*, Paris, 1909, p. 457; A. Sézary, *Gazette des hôpitaux*, Paris, 1912, lxxxv, p. 125; F. S. Meara and M. Goodridge, *Amer. Journ. Med. Sci.*, Philadelphia, 1912, vol. cxliii, p. 393; W. Hildebrandt, *Münch. med. Woch.*, 1907, liv, p. 310; A. Chauffard et J. Troisier, "Erythème noueux expérimental par injection intradermique de tuberculine," *Bull. de la Soc. méd. des Hôpitaux de Paris*, 1909, xxvii, p. 7, and p. 772; G. Thibierge et P. Gastinel, "Reproduction expérimentale de certaines dermatoses par l'injection intradermique de tuberculine," *ibid.*, 1909, xxvii, p. 757.

† L. Landouzy, *Association Française pour l'avancement des Sciences*, Reims, 1907, xxxvi, Part I, p. 337.

A boy, aged 3½ years. General health is good. No family history of ichthyosis. Present condition: Trunk, especially the back, shows marked ichthyosis (serpentina type); scalp crusted and covered with scales, which encroach half an inch over forehead and end abruptly; skin of face most exceptionally smooth and soft, in fact is of a notably beautiful complexion; extremities partially covered with scales with areas of smooth skin. The child was born with a "parchment skin," and has never been perfectly free from the ichthyotic condition, which sometimes involves the whole face, despite its present perfect freedom from the trouble; at quite irregular periods the scaly skin clears up (often spontaneously), leaving a perfectly smooth, soft skin. This smooth skin later becomes scaly again, without any erythema or febrile symptoms. The clearing up by a peeling process is aided by ordinary remedies for ichthyosis, such as resorcin and glycerine of starch, etc. The condition is always much worse in the summer.

CURRENT LITERATURE.

A CASE OF SPOROTRICHIAL SEPTICÆMIA. Menaham Hodara. (*Archiv f. Derm. u. Syph.*, 1911, cx, p. 387.)

The patient affected by the disease was a doctor, and many of the notes of the case are by the patient himself.

The disease began when the patient was in good health. The first symptoms noticed were an easily occurring fatigue and a tendency to excessive perspiration. A few weeks later he noticed that he had a small amount of fever (37·6°) which rose three days later to 38·5°. He then began to have a slight stiffness of the muscles and the diaphoresis increased more and more. Four days after the commencement of his illness he was attacked by severe pain in the right side of the back, which was taken to be pleurodynia. General rheumatoid pains of great severity then supervened, and he began to vomit everything he took, including even ice water.

On the eighteenth day the blood was tested for Malta fever but the result was negative. After a certain number of rigors from the twelfth to the eighteenth day the temperature began to fall, and then took an undulant character which lasted for eleven months. On the fortieth day an eruption occurred, which began on the face and spread in a few days to the whole of the body. Towards the end of the second month an epididymo-orchitis began, first on the left side and then on the right.

The blood was now again examined for Malta fever and the result of the test was positive, and this diagnosis was accordingly accepted by his doctors. At the beginning of the seventh month ocular symptoms set in, beginning with

an episcleritis and followed by an iritis which lasted two or three months. After the cure of the first eye the second eye was affected and the trouble lasted for a year.

The eruption was in the form of small papules with very small vesiculo-pustules upon them. The papules healed spontaneously and left very marked pigmentation. Some of the lesions resembled papulo-necrotic tuberculides, others papular syphilides, and the whole eruption lasted sixteen months. There was also ulceration of the tonsils.

The general course of the disease was extremely puzzling to the doctors who had care of the patient, and finally the possibility of its being sporotrichosic occurred to them, and a culture on Sabouraud's medium was made from the pus of one of the cutaneous lesions, with the result that a culture of sporotrichium was obtained.

Unfortunately the patient tolerated iodides extremely badly and the case was not complete when reported. It is worth noting that after the diagnosis had been established the blood was again examined for three diseases with the following result: Sero-agglutination with the *Micrococcus melitensis* in one fiftieth dilution negative; sero-diagnosis by the method of Porges for syphilis negative: sero-agglutination with an old culture of sporotrichosis in dilution of one three hundredth strongly positive.

A. W.

ON DERMATITIS NODULARIS NECROTICA. V. Klingmüller. (*Archiv f. Derm. u. Syph.*, 1911, cx, p. 419.)

The patient was a girl, aged 20 years, with a history of pleurisy and a doubtful condition of one apex. From her tenth to her eighteenth year she was troubled with a recurrent eruption which showed three types of lesions.

(1) Numerous hempseed-sized infiltrated bluish-red nodules, which became hæmorrhagic and then resolved, leaving a pigmented area.

(2) Primary flat infiltrated areas without any papule or pustule formation.

(3) Transitory red or blue erythema-like spots, which either disappeared rapidly or formed the basis for the two other types.

The histology was not dissimilar to that which we are accustomed to see in the tuberculides, but the patient's reaction to old tuberculin was not very typical as no local reaction occurred. Klingmüller sums up against its being a tuberculide. In this country I do not think we should have any hesitation in classing the lesions with the tuberculides from their clinical and histological structure, and the facts that there was almost undoubted disease of the lungs, and the patient gave a positive constitutional reaction with old tuberculin.

A. W.

A CASE OF MERCURIAL POISONING. F. Juliusberg. (*Archiv f. Derm. u. Syph.*, 1911, cx, p. 409.)

A strong woman, aged 45 years, received seven inunctions of 4 grm. of 33½ per cent. mercury vasogen. There was a rise of temperature without other symptoms. This disappeared in a few days, and the inunction was then resumed. Up to the twenty-seventh inunction no further symptoms occurred, but after this a fulminating mercurial intoxication supervened and the patient died in fifteen

days. The symptoms were high temperature, a scarlatiniform eruption, and severe damage to the kidneys and intestines, but the oral cavity remained intact.

A. W.

ON PEMPHIGUS. Max Joseph. (*Archiv f. Derm. u. Syph.*, 1911, cx, p. 399.)

Joseph begins with the statement that Kaposi in his practice reckoned pemphigus to constitute a proportion of 1 in 300, while the American Dermatological Society estimates it at 1 in 1000. He considers that everyone who has watched the Vienna clinics must come to the conclusion that it is far commoner there than elsewhere, and he considers it either due to the place or the race. He then goes on to mention some unusual cases of the disease. In an old lady, aged 48 years, the disease began with a sudden and severe epistaxis occurring in the night. The diagnosis was doubtful for a time, but then pemphigus began to show itself at the various muco-cutaneous margins, and the patient died of the disease after two and a half months.

In a second case the disease began in a young, newly married woman, aged 24 years, with pain in the throat. At first the diagnosis of syphilis was made, but this was given up and the case became plainly pemphigoid by the occurrence of blisters on the body. On the chance of its being a hydroa gestationis the pregnancy was determined, but the result was not favourable and the patient died soon afterwards.

Joseph then alludes to one or two cases in which the itching was so prominent a symptom that it led to error of diagnosis.

Finally he deals with the treatment, with which he has not had much success, but says that he has not yet had an opportunity of trying salvarsan.

A. W.

CONTRIBUTION TO THE QUESTION OF TATTOOING AND SYPHILIS. W. Holland. (*Archiv f. Derm. u. Syph.* 1911, cx, p. 393.)

The report deals with four cases in which the presence of tattoo-marks had determined the site of the eruption in syphilis.

Attention is called to the fact, which has been previously noted, that it is only in the blue (*i. e.* Indian ink) marks that the eruption occurs and not in the red (cinnabar). Holland deduces from this the idea that the cinnabar, although so insoluble, has sufficient mercurial action to interfere with the development of the rash in these situations.

A. W.

THE MOTTLED CHIN IN SYPHILIS. William Trimble, M.D. (*Journ. of Cut. Dis.*, vol. xxix, November, 1911, No. 11, p. 569).

In a number of cases of early syphilis, that is to say during the first few weeks or perhaps months of the disease, the chin is marked with a macular variegated eruption, which is characteristic, and the same in every case in which it is present varying only in degree. It occurs especially in that part of the chin under or near each commissure of the mouth. Sometimes the eruption has a tendency to spread upward, encroaching slightly on each side of the upper lip, thus giving it the appearance of surrounding the mouth; however, it is mainly confined to the chin. These dingy or dirty shades are mingled together

with the dusky red, shading out to light brownish tints, which predominate at the sides, and a marked but extremely light-yellowish hue spreads over the whole surface. In a number of instances there is also a suspicion of lilac. The point of the chin is in most cases clear, thus making a sharp high-light against the eruption. In a great majority of the cases the lesion is macular, but in a few instances where it is intense the mild infiltration may slightly raise the epidermis; in such cases it might be termed maculo-papular. A very slight desquamation is observed at times, which is perhaps due to some of the lesions undergoing absorption. This symptom, which has been noticed for a number of years past, occurs more frequently in women than in men; in fact, nearly all the cases in which it has been observed have been women; its greater rarity in men is probably due to the growth of hair on the face, and since it is mainly a colour sign it is thereby obscured. It is occasionally observed in very young men and in those who keep clean shaved. The condition is sometimes more pronounced in those patients affected with a mild seborrhœa of the face, although seborrhœa is by no means a necessary concomitant for its development.

Though comparatively rare, it is not extremely uncommon; when present it is pathognomonic—almost as much so as the classical sign, the pigmentary syphilide of the neck, described by the French.

It sometimes precedes the macular eruption; it frequently occurs simultaneously with the roseola, and it may remain for a short while after the other symptoms have disappeared. It is distinct from the well-known annular syphilide so common in the negro, and also from the ordinary well-defined papular eruption which is frequently found on the face.

The communication is accompanied by plates. J. H. Sequeira.

EOSINOPHILIA IN SCABIES. J. A. Kolmer, M.D. (*Journ. of Cut. Dis.*, xxix, June, 1911, p. 339.)

A study of eighteen cases of scabies occurring in a epidemic in an institution for children. The disease was found to be accompanied by a mild leucocytosis according to its degree of severity, the number of leucocytes reaching normal as the disease is cured. The eosinophilia varied from 3 to 11 per cent., and in twelve cases was above 5 per cent. J. H. Sequeira.

ERYTHEMA NODOSUM SYPHILITICUM. F. J. Leviseur, M.D. (*Journ. of Cut. Dis.*, November, 1911, vol. xxix, No. 11, p. 579.)

In this paper Dr. Leviseur has collected the observations of numerous authors since Mauriac in 1880 first described this condition. He comments on the resemblance between Erythema nodosum syphiliticum and Bazin's disease, and the liability of its being mistaken for rheumatism or an accidental combination of rheumatism and syphilis. J. H. Sequeira.

A FATAL CASE OF BLASTOMYCOSIS. F. J. Shepherd, M.D. (*Journ. of Cut. Dis.*, November, 1911, vol. xxix, No. 11, p. 588.)

The patient was an Italian, aged 25 years, who had been in Canada working as a railway navvy for two years, but recently he had lived in Montreal. The eruption had been in evidence for four months before he came under Dr.

Shepherd's care. It was then widely spread on the nose and cheeks, there was also a sinus discharging pus leading down to diseased bone at the sternal end of the clavicle, and a large fluctuating swelling over the second lumbar vertebra. Cultures from the pus of the various lesions showed blastomyces. In spite of the exhibition of large doses of iodides the case ran a pyæmic course, abscesses appearing in the axilla, over each buttock and in the popliteal space. The left tibia, left humerus and right metatarus were also affected. Eventually the patient succumbed, and at the autopsy blastomycosis of the skin, bones, peritoneum lymphatic glands, pleuræ and lungs was found. Both kidneys and the left adrenal, the prostate and œsophagus were also involved.

This appears to be the first case of fatal generalised blastomycosis recognised in Canada. Some excellent photographs and micro-photographs are given.

J. H. Sequeira.

QUARTERLY SURVEY OF DERMATOLOGICAL LITERATURE.

ERYTHEMAS, INFLAMMATIONS, ETC.

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